



BALANCING ACT

finding the right balance:

curbing soaring health care costs

Shocked at how much health care costs have risen? Well, you ain't seen nothing yet, say a group of experts who are forecasting a \$2,500 increase in a family of four's annual medical expense over the next five years. And that figure, they warn, may be too conservative.

Right now, these experts say, the health care system is spinning out of control. And the best way to regain control – maybe the only way – is for purchasers and consumers to lead the way toward a solution that requires sacrifices from all the players on the health care field: employers, government, providers, insurers, pharmaceutical and medical technology companies, and consumers.

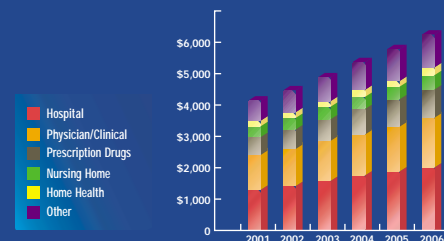
These conclusions are based on projections released recently by Milliman USA (formerly Milliman & Robertson), a prominent consulting and actuarial firm. Milliman consultants estimate that

per capita health care costs will increase 44% by 2006, higher than the 39% increase predicted by the federal Office of the Actuary. Whether 39% or 44%, the impact will be dramatic.

As a result of these increases, many employers are forcing their employees to shoulder a greater portion of the health care cost burden. As employee premium payments and out-of-pocket spending for non-covered services continue to grow, Milliman says that the average consumer's health care tab will increase by 55% between 2001 and 2006. This translates into an increase of \$2,500 in annual household medical spending (premium share and out-of-pocket combined) for an average family of four by the end of that five-year period.

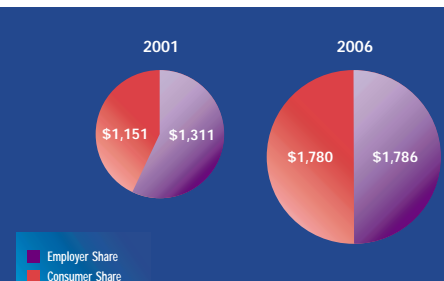
More sobering still, says Mick Diede, consulting actuary in Milliman's Atlanta office and a member of the team that developed the projections, these figures may be low. "These estimates assume that things continue on their current trajectory,"

he says. "If more employers start adopting strategies like defined contribution, for example, the increase for consumers could be worse." The defined contribution arrangement, in which an employer offers employees a set amount of non-taxable benefit dollars to "spend" as they choose, is a hot topic of discussion among



Per capita US health care expenditures by use

Source: Milliman USA Estimates



Per capita healthcare expenditures by source: employer-sponsored health insurance

Source: Milliman USA Estimates



employers, and many experts say these plans are gaining in popularity.

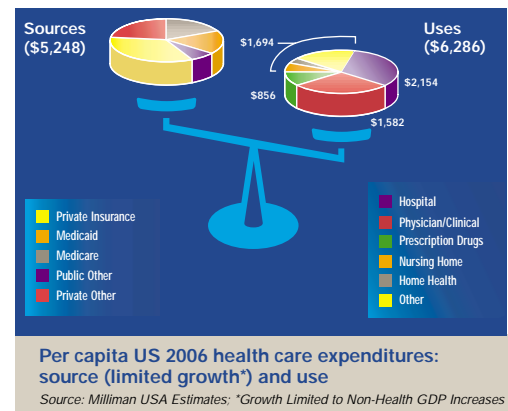
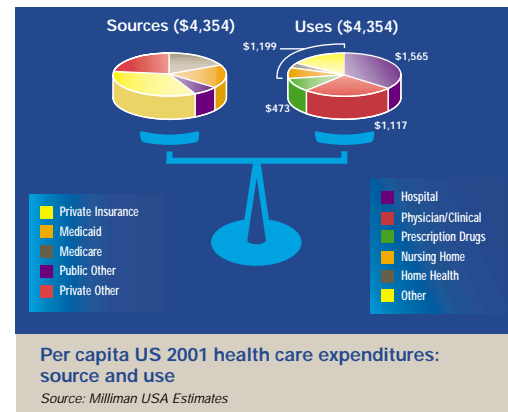
"The challenge over the next few years will be to manage the rate of cost increase, while still working to preserve and improve quality and access," says Diede. "Keeping costs under control should not come at the expense of quality: These need to be complementary goals." Diede adds that the Milliman consultants expect consumers and purchasers to play a big role in pushing for both these objectives, by pressuring other stakeholder groups to shoulder more responsibility on both fronts.

Reducing the increase in health care spending – or even just keeping it at the same level as the growth in the Gross Domestic Product (GDP) – will require the health care delivery system to spend around 4% less than projected costs in each of the next five years, achieving a total savings of 18% by 2006. This means that all recipients of health care dollars – hospitals, doctors, pharmaceutical companies,

long-term care facilities, and home health providers – will have to find ways to cut back.

"In the 90s, everyone thought managed care was going to dramatically reduce health care inflation," says Milliman's Patrick Dunks, consulting actuary and team member in Milwaukee. "Managed care companies did significantly reduce health care inflation by negotiating lower reimbursement levels with providers and promoting improved quality and efficiency for many health care services. Over time, however, many patients and providers have become disillusioned with managed care because of their perception of cost-cutting measures, limits to access, and bureaucratic red-tape. With market share no longer growing, the pendulum is now swinging back: many hospitals and physicians are successfully negotiating fee increases well in excess of general inflation to make up for low reimbursement in recent years. Managed care alone couldn't keep costs down, nor can any other sector."

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a fragile balance

While everyone in the system has a role to play in reducing costs, not everyone is equally motivated to do so. "Consumers, employers and government will feel the brunt of the cost increases coming down the pike," says Stuart Rachlin, consulting actuary and team member from Tampa. "They clearly have the strongest incentive to push for reductions in health care spending."

While they might have the strongest incentive, consumers and employers will not be the only constituency affected by the dramatic rise in costs. The U.S. health care system relies on an

imperfect balance of stakeholders and their interests. A dramatic cost increase such as the one predicted by Milliman can't help but affect every party supporting what is, indeed, a fragile balance. Specifically, say Milliman consultants, if the current scenario is allowed to play out unchallenged, everyone stands to lose something. For example:

- **Employers**, who already pay high premiums, will face staggering cost increases. Small employers, many already struggling to provide benefits, may be priced out of the market and drop coverage altogether.

Those who decide to scale back benefits will lose the competitive recruiting edge that benefits often provide, and suffer higher employee dissatisfaction. High health insurance costs will also make it more difficult for U.S. companies to meet shareholder expectations and compete in the global economy.

- **Consumers** will probably be the biggest losers. Some will lose insurance coverage altogether. Those who manage to retain coverage will bear a substantially larger financial burden and may see their benefits reduced. Either way, consumers will be more likely to forego care because of its expense, which may result in poorer health and a lower quality of life.

- **The government**, which plays many roles, from regulator to purchaser, will feel the impact of cost increases most in buying coverage for employees and Medicare/Medicaid beneficiaries. As the largest purchaser of health care, the government will shoulder a huge burden of additional costs, which will undoubtedly be passed on in increasing proportions to government employees, taxpayers, and providers of care to Medicare and Medicaid patients. As a regulator, the government will come under growing pressure to mitigate the rapid cost increases.

- **Providers**, especially institutional providers such as hospitals and long-term care facilities, will ultimately feel increased financial pressures, particularly as their government reimbursements shrink. Some, unable to bear the financial burden will close. Individual providers, likely to have even less bargaining power than they currently have, will be pressured to do more for less.

- **Insurers**, especially managed care organizations, will feel continued pressure from purchasers to keep costs down. At the same time, they will be pressured by providers such as hospitals and physician networks to increase reimbursements. Some will lose market share as employers self-insure, contract directly with providers, and utilize purchasing coalitions.

- **Pharmaceutical and medical technology companies** may initially benefit from increased spending, but will undoubtedly suffer in the court of public opinion if costs continue to spiral upward and drugs and devices become increasingly unaffordable. Public pressure on lawmakers to create affordable access to drugs and devices will grow, particularly as the population continues to age. However, if law-makers attempt to limit profits, drug and technology companies may respond by

reducing their investment in research and development.

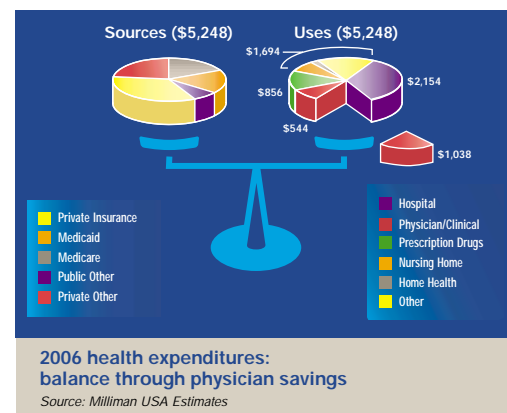
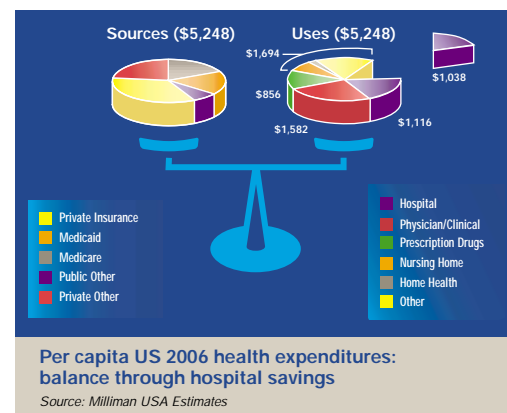
For those who remain skeptical that the solution must involve everyone from patients to providers to purchasers of coverage, Milliman offers, by way of example, two hypothetical – and highly unrealistic – scenarios in which only one group shoulders the burden of keeping cost increases in line with non-health GDP growth:

- If all of the cost reductions necessary to control health care inflation during the next five years were made in the hospital sector spending would have to be cut by nearly 50%. This paring could not be achieved without some combination of staff

reductions, elimination of services, reduced reimbursement, and outright hospital closures.

- If required savings were wrung solely from the physician sector, doctors' revenues would drop by about 65%.

Neither of these solutions, or others like them, is desirable or even viable. "The only practical way to achieve balanced cost control is to drive change in each sector," says Pat Zenner, healthcare management consultant and team member in Milliman's New York office. "And that will not happen at once, but over time, as relative power shifts among health care stakeholders."



health care's **hot** potato

With providers demanding and getting higher reimbursement from HMOs and with HMO spending on drugs increasing dramatically (more than 20% in the past year), Milliman's 2000 HMO Intercompany Rate Survey reports HMOs are raising their rates an average of 9 to 15 percent. Other insurers are raising rates similarly. Employers, socked with higher premiums, are passing more of the cost along to consumers. "The pressures are passed around within the system like a hot potato, when in fact the players need to stop the game and figure out a different way to play together," says Zenner.

That won't happen easily. "Consumers and employers

will feel the pressure first, and they'll begin to fight back. But over time, everyone will begin to feel pressure of one kind or another and respond accordingly. We don't expect each sector to drop its own agenda and magically come together around shared goals – that would be naïve. But there are still plenty of ways in which everyone can play a role in lowering costs without sacrificing too much."

And what might some of those ways be? "One imperative is that health care delivery must function better as an organized system," says Rachlin. "There needs to be better coordination and more collaboration. Employers need to work with health plans and providers to

improve access and quality while controlling costs," says Rachlin. "We are already seeing this happen in some parts of the country, where new types of provider networks are working under more quality-driven reimbursement arrangements. Health plans are integral to this type of arrangement, because they can provide more complete data on provider performance and clinical outcomes."

Moreover, providers can work together to better coordinate patient care. Pharmaceutical companies can work with providers and insurers to assure the availability of cost-effective and affordable drugs. In addition to these types of creative partnerships, the Milliman group also identified the following opportunities for efficiencies within each stakeholder group:

Employers/Purchasers

- **Give employees the right incentives.** Well-designed benefit plans make consumers more aware of underlying costs and provide incentives to use resources wisely. Purchasers should work with insurers to design benefits that reward conservation and cost-effective use of the
- **Educate employees.** Employees who understand the true cost of care, and their role in keeping health care

system, such as a tiered drug benefit that requires higher copayments for brand-name drugs than for generics, or benefits that charge higher copayments for out-of-network services and inappropriate emergency room use. As another example, some HMOs have begun replacing fixed dollar copayments with coinsurance, linking consumers more directly to the true cost of care.

- **Pay for cost-effective preventive care.** Preventive care can save money by reducing the need for more costly treatments down the road. True, the savings accrue in the long term and, with employee mobility, employers may not realize short-term savings. The broader view is that preventive care saves the system money over time, benefiting everyone – employers, plans, and consumers alike. Moreover, preventing disease and detecting it early enhances quality of life and productivity for employees.



inflation under control, will help save the system money. Employers can sponsor training sessions for employees on how to effectively navigate their health care system and appropriately use its resources.

- **Join forces with other purchasers.** Purchaser coalitions throughout the country have successfully pushed for higher quality in health care, lower rates, and greater access to services. Coalitions have clout that can bring about change. Examples include the Midwest Business Group on Health, a coalition of employers working together to improve the quality and cost-effectiveness of health services, and the Leapfrog Group, a Washington, D.C.-based group of Fortune 500 companies and other large health care purchasers committed to a common set of purchasing principles to drive “leaps” in patient safety.
- **Be responsible in requests for quality data.** Employers should seek statistically meaningful data about quality across employee groups, working with other employers to standardize requests and limit demands for costly, customized data.

Consumers

■ **Become cost conscious health care consumers.**

Many consumers have been sheltered from the true cost of health care by purchasers who pay the lion's share of the premium and by the low copayments they pay when they see the doctor. Now that many employers are requiring workers to pay more of their premiums, consumers are getting a clearer picture of what health care really costs. Regardless of how much or how little you pay toward the cost of your care, says Milliman, you must learn about, and care about, its true cost, and accept responsibility for using services prudently, as if you were directly paying the entire cost. In fact, consumers are paying the entire cost, much of it through indirect means such as lower wages and higher taxes.

- **Have more realistic expectations.** Emotion and advertising often trump economy in health care decision-making. Our expectations are high about everything from how far we should have to travel to see a specialist to how quickly we can start taking the newest wonder drug, or even whether and when we need an antibiotic. We



think more is better, and high-tech is better still, when often this only means higher cost, not better care. Being a better-informed and realistic health care consumer means finding the right balance between asking your doctor about the latest drugs and treatments, and being prudent enough to use the least expensive appropriate tests, procedures and medications first.

- **Take more personal responsibility.** A healthy lifestyle reduces the need for health care. Consumers who take greater responsibility for their overall health, lessen the demands on the system. In fact, some consumers can benefit financially from pursuing a healthy lifestyle. Some employers offer employees financial incentives such as reduced premiums if they join a health club or quit smoking.

The Government

■ **Reduce mandates.**

Government mandates to expand coverage often increase cost without improving quality. For example, requiring coverage of expensive infertility treatment will spread the cost over a number of payers; reduced cost sharing for potential users will lead to higher overall utilization and therefore higher system-wide costs. Service mandates (such as alcoholism treatment, or TMJ coverage) and provider mandates (such as chiropractors or naturopaths) can also increase public expectations and sometimes lead to additional utilization.

- **Create payment mechanisms that provide proper incentives.** As a purchaser, the government can design benefit plans that encourage consumers to use resources wisely. As the overseer of federally funded programs like

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Medicare, the government can design reimbursement approaches for hospitals and other providers that include incentives to treat patients in the least expensive appropriate setting.

- **Create responsible legislation/regulation.** Laws designed to protect patients or expand their choices often cost them money, and the right balance must be found between these priorities. At this writing, Congress

and the President are debating the merits of legislation creating a Patient's Bill of Rights, which will give patients more legal recourse if care is denied, but which is predicted by the Congressional Budget Office to increase health care premiums by about 4%.

Providers

- **Accept accountability for resource management.** Physicians direct about 70% of health care spending.

They have enormous influence over costs, one patient at a time. The challenge they face is to advance quality and meet the demands of employers and purchasers for improved performance while keeping overall costs under control.

- **Accept ownership of quality issues.** Purchasers believe that better quality often leads to reduced costs, so they have promoted use of quality standards and hold provider organizations accountable for meeting those standards. Physicians and institutional providers must either accept these standards or establish their own expectations for their profession and work to improve access, reduce treatment variation through the practice of evidence-based medicine, and improve overall quality of care.
- **Pursue collaborative problem solving with insurers.** Coronary artery disease is the leading cause of death in the United States. The American Heart Association promotes use of beta blocking drugs as the first choice for long-term control of angina; yet, many patients do not fill a beta-blocker prescription when discharged from the hospital after a heart attack. Insurers and providers can work together to improve appropriate drug use by identifying non-compliant patients through drug claims
- **Practice demand and expectation management.** This involves education for both physicians and patients. Patients increasingly bring their doctors articles from the Internet about new treatments or technology they want, or press for an antibiotic when it is not necessary. Physicians need to educate patients about appropriate care, and resist the temptation to give in to pressure.
- **Offer multiple means of patient contact.** A patient/doctor visit is not the only way to offer care. Many doctors are beginning to use email, the telephone, the Internet, and group visits for patients with similar diagnoses as innovative and less costly ways to provide patients with information and care.

Insurers

- **Encourage appropriate financial incentives in plan design.** Benefit plans should include incentives that guide consumers toward more responsible and cost-efficient use of health care resources, such as lower copayments for generic drugs or incentives to use cost-effective high quality providers.

Back to Basics: How Consumers Can Help Control Health Care Spending

While lifting a heavy box at home, Alan wrenches his back, and feels acute pain. Next door, Zach twists his back wrestling with his eight-year-old son. Both have a history of back problems, experience a good deal of pain, require medical attention, and eventually recover at about the same rate. But the different ways in which they choose to access care, along with their expectations about what constitutes appropriate care, make an enormous difference in the amount of money that is spent on their care, although their outcomes are virtually identical.

Alan visits his primary care physician's office the next day. They discuss his symptoms and history of back problems and agree that pain relief and restricted activities are the best remedies. The physician writes Alan a prescription for a generic pain medication and gives him information on the back-strengthening exercises he recommends. Alan takes a week off work, begins his

exercises, sees his doctor once more for a follow-up visit, returns to a light schedule, and feels fine in about six weeks. Total cost: \$250. Alan's cost: \$15.

Zach doesn't want to wait to see his physician and goes to his local emergency room. The attending physician orders an x-ray. The x-ray is inconclusive and the physician suggests that Zach talk with his primary care doctor about having an MRI, and that he pursue some physical therapy. He sends him home with a prescription for a high-priced brand-name drug for pain relief.

Zach calls his primary care doctor and schedules a visit, at which he pushes for an MRI and physical therapy. The physician, pressed for time, nods and orders both. The MRI shows no damage. Zach takes one week off work and after 16 physical therapy visits and two follow-up visits with his doctor, feels better in about six weeks. Total cost: \$2,700. Zach's cost: \$125.

- **Reward and support providers for quality and prevention.** Providers should be given financial incentives to improve access and quality, and to provide preventive care and screening tests. Insurers can provide physicians with information about patient compliance with medication and preventive services, patient education materials, data showing them how they compare to their peers on key quality measures, and support for alternative means of patient contact such as telephone, email, or Internet.

- **Educate consumers on appropriate use of resources.** Insurers can join providers and employers in helping consumers become prudent users of health care services.

- **Pursue efficiency.** Administrative complexity increases cost. Carriers should work to streamline routine processes. Recent federal legislation promotes standardization of provider data layouts. Insurers need to capture all the information contained in the claim records rather than just that needed to process claims. More complete data is the foundation of quality and efficiency improvement studies.

Pharmaceutical and Medical Technology Companies

New technology, and in particular new drugs, have contributed significantly to health care inflation. Milliman's 2000 HMO

Intercompany Rate Survey shows spending on pharmaceuticals accounted for 35% of HMO medical cost increases over the last year.

Commonly cited "solutions" directed toward decreasing pharmaceutical costs include pressuring the industry to curb development of "me too" drugs, and demonstrate more responsible marketing to consumers and physicians.

But Milliman experts believe it is naïve to think pharmaceutical and medical technology companies will take it upon themselves to cut spending on the products they sell. Rather, they suggest that external forces can promote more cost-effective use of these therapies through the following actions:

- **Employers:** Move away from fixed dollar copays to coinsurance on pharmaceuticals; demand more accountability from pharmacy benefit managers and insurers.

- **Consumers:** Don't expect prescriptions for a new drug when a lower cost alternative is also effective; seek objective information on treatment alternatives rather than blindly following advertising.

- **Insurers:** Provide consumers with objective information about various treatments, pressure pharmaceutical and medical technology companies to provide cost/benefit analyses to improve the chance these treatments will be covered.

Bringing Uniformity to Medicare Hospital Rates

The federal government has developed numerous provider reimbursement systems for health care services intended to limit growth in spending for specific services (or groups of services). For instance, under the Medicare program, hospitals are generally paid a predetermined rate based on the resources they are expected to use in treating Medicare patients with similar diagnoses, regardless of the resources actually consumed for a given patient. The payment mechanism, which classifies admissions into Diagnosis Related Groups, or DRGs, helps to reduce reliance on hospital charges as a basis for payment; better manage per unit reimbursement trends; and more appropriately compare costs between hospitals. Under this payment mechanism, once a patient is admitted, a hospital has a financial incentive to provide care in the most cost effective manner possible that is clinically appropriate.

More recently, the federal government implemented a new reimbursement system for Medicare patients using hospital services on an out-patient basis. Most services are classified using the Ambulatory Payment

Classification (APC) System, which groups similar services into categories based on expected resource use. The payment system establishes a predetermined rate for the hospital component of each service (excluding professional services) provided to a Medicare beneficiary in a geographic region.

The uniform classification system for hospital outpatient services should allow for meaningful comparisons of cost per service between hospitals, which is a significant change from the recent past when each hospital appeared to have its own classification method and comparisons were difficult, if at all possible. The payment system also establishes a benchmark for payment other than the customary discount from billed charges used most recently. Billed charges in many areas of the country are much like list price on a new car, they hold little meaning because nobody pays that amount. By establishing a predetermined fee for each service, insurers may be able to better manage inflation on per unit cost basis rather than having no control over increases in hospital billed charges as they occur.

- **Providers:** Educate patients on prudent use of pharmaceuticals and medical technology and prescribe the lowest cost effective therapy.

- **Government:** Facilitate the dissemination of objective cost-benefit information on new therapies. Far-reaching governmental interventions such as price controls and reduced patent protection are controversial.

moving beyond blame

Now, with pressure clearly building and the cost of inaction high, the imperative to act is strong. And while consumers are likely to be the biggest losers if nothing is done to mitigate the increases on the horizon, they will not be the only losers. Every sector on the healthcare landscape will suffer and the pressure for a “government solution” will build. This will undoubtedly divide, rather than unite, the diverse interests on the healthcare playing field, as each would vie for the most favorable regulatory position in a struggle for its own survival.

“Too often the debate about controlling health care costs inclines toward blame,” says Dunks. “But it’s important for all the players to recognize the importance of interdependence in this delicate balancing act. It’s like a tightrope walker who is balancing all these competing weights on a pole. If one shifts too far, the balance is upset. Everyone has a role to play.”

The complexity of our health care landscape and of the relationships among its players does not support simple solutions. Each entity naturally works to further its own self-interest while meeting its

Reducing Variation Will Reduce Costs

There is considerable variation in the rates of certain types of surgery in the United States. Analysis of this variation indicates that physician preference, rather than evidence-based medicine, is guiding many decisions. The 1999 Dartmouth Atlas of Health Care reported that in 1995-1996, rates of coronary artery bypass grafting among Medicare enrollees in Redding, CA,

for example, were 87% higher than the national average, while the rate in Albuquerque, NM was 50% lower.

If providers follow evidence-based guidelines, inform patients about treatment risks and benefits, and involve them in decision-making, variation in surgical rates would be greatly reduced.

customers’ needs. This in itself is a delicate balancing act, made much more challenging by the inter-relationships among all the players. But the self-interest of each group is also tied to the success of the “system” as a whole. And it is within that context, that fragile balance, that each group must find its incentive to act responsibly as we sort out an effective approach to curbing steadily increasing costs.

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About Milliman USA

Milliman USA is a firm of consultants and actuaries serving the full spectrum of business, governmental and financial organizations. Milliman USA professionals offer their clients objective advice and a superior work product based on the best tools and data available.

Milliman USA's Health Cost Index Report™ has been a source of health care trend forecasts across the country

since 1988. The Health Cost Guidelines, which employ the Health Cost Index in their trend rates, serve as a basis for forecasting health care utilization and costs and are used, either through leasing arrangements or in consulting assignments, as a framework for pricing health care and forecasting utilization by the majority of health insurers, HMOs, and Blue Cross plans across the United States. Milliman USA's clinical Care Guidelines™, which present

evidence-based best practices for the treatment of a wide variety of health care conditions, are utilized by payers who deliver health care to more than 100 million Americans.

Founded in 1947, Milliman USA is located in 34 cities throughout the United States and in principal cities around the world. Milliman USA is a founding member of Milliman Global, an international network of actuaries and consultants. Milliman USA

has more than 1,750 employees, including a consulting staff of more than 700 qualified consultants and actuaries. Milliman Global has approximately 2,600 employees worldwide.

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